Financial Agreement

We ask that all patients read our financial policy as well as complete our Patient Information form prior to seeing the Dentist. Payments for services are due at the time services are rendered. We accept cash, check, credit cards and approved financing. We may accept assignment insurance benefits however, you must understand that: 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party in that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "unusual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing. 2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in their contracts. Some insurance companies arbitrarily select certain services they will not cover. 3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. 4. I understand that employees of Dentures Today are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company. 5. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. 6.   If your insurance company does not pay, you are responsible for your payment. If your insurance company does not pay in full within 45 days, we may require you to pay the balance.7. There will be a fee charged for returned checks. 8. Balances older than 60 days may be subject to collection placement and fees. 9. I authorize payments from my insurance carrier be made directly to the Dentist. 10. I authorize this office to release necessary medical or dental information about me to my insurance carrier. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us, so we may assist you in management of your account.

FIXED OR REMOVABLE PROSTHETICS, such as dentures, crowns, bridges, or partial dentures, are understood to be a product that is uniquely suited to each patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made. AS A COURTESY TO YOU, Dentures Today will, if necessary, accept 50% of this amount at the time of impression, the remaining being 50% due at the time of delivery.

We accept insurance for payment of the coverage portion; however, you must pay your portion at the time the services are rendered. PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND A PROPER FIT. If you fail to have your prosthetics seated within 60 days from the date of impression, a second impression must be made, and you will be charged an additional charge. ALL X-RAYS TAKEN ARE A PART OF OUR PERMANENT RECORDS. THERE IS A DUPLICATION CHARGE FOR ANY X-RAYS REMOVED FROM THIS OFFICE. Again, thank you for choosing Dentures Today as your dental care provider. We appreciate your trust in us and the opportunity to serve you.

Patient Signature: _____ Date:_____/____/_____

PRIVACY ACT

SECTION A: The Patient

Name: _____ Telephone: (_____)-_____-_____

Address: _____ City:_____ State:_____ Zip:_____

Social Security Number: _____-_____-_____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice
I, _____, acknowledge that I have received Notice of Privacy Practices from the above-named practice.
Signature:_____

If a personal representative signs this authorization on behalf of the individual, complete the following:
Personal Representatives Name: _____
Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt
Describe your Good Faith Effort to Obtain Acknowledgement of Receipt_____
Describe your Good Faith Effort to obtain individual's signature on this form: _____

_____

Describe why the individual would not sign this form: _____

SIGNATURE:
I attest that the above information is correct:
***Signature:* _____ *Date:* ____ /____ /_____**
ACKNOWLEDGMENT OF RECIEPT OF PRIVACY PRACTICES NOTICE